



HEALTH UPDATE

Missouri Department of Health and Senior Services

Paula F. Nickelson, Director

February 27, 2024

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Phone: 800-392-0272
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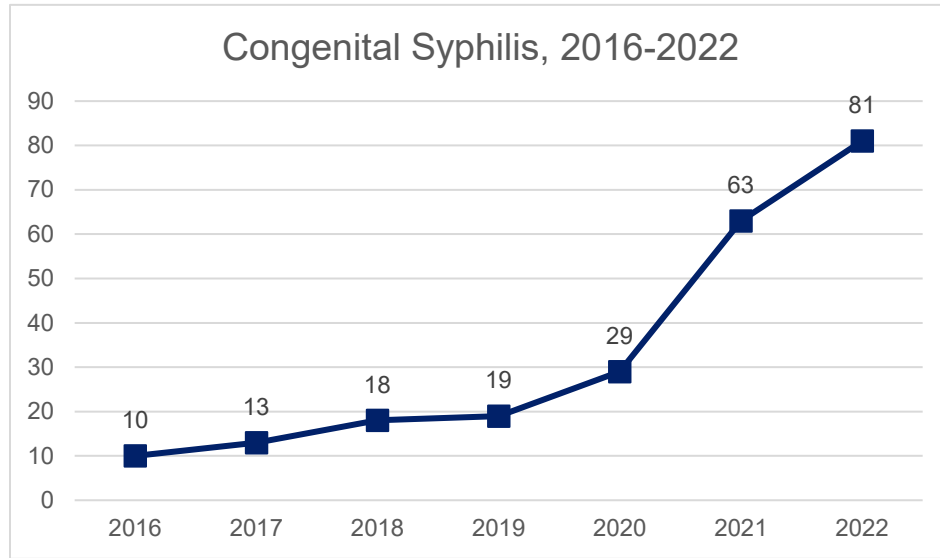
Congenital Syphilis in Missouri

Summary

- Cases of congenital syphilis continue to increase in Missouri. In 2022, 81 congenital syphilis cases were reported in Missouri, compared to 10 cases in 2016. The number of cases in 2022 represent the highest reported in nearly 30 years (97 cases in 1993).
- The number of early syphilis cases reported in Missouri increased by 230% from 2016 to 2022, from 676 cases to 2,228 cases.
- Missouri health care providers should assess the sexual health of all patients and discuss STDs and HIV risks for the patient and partners of the patient. Providers should routinely test for syphilis in individuals who have signs or symptoms suggestive of infection or risk factors for infection. Individuals exposed to syphilis within the past 90 days should receive testing and preventive treatment even if testing is negative.
- All pregnant women in Missouri should be screened for syphilis three times regardless of perceived risk: (1) at the first prenatal visit, (2) in the third trimester (28 weeks), and (3) at delivery. No infant should leave the hospital without the mother's serological status having been documented during pregnancy, preferably including the test result during the delivery hospitalization.
- Pregnant women with syphilis should be treated with one to three shots of benzathine penicillin G, 2.4 million units IM, depending on the stage of syphilis ([see CDC treatment guidelines](#)). Penicillin G is the only known effective antimicrobial for preventing maternal transmission to the fetus and treating fetal infection. Pregnant women who have a history of penicillin allergy must be desensitized by an allergist and treated with penicillin.
- Congenital syphilis should be considered in all stillbirths after 20 weeks and in infants of mothers with evidence of syphilis infection during pregnancy, especially if syphilis is newly acquired during pregnancy. Infected infants can be asymptomatic at birth but can develop serious symptoms in the neonatal period or later in life.

Congenital Syphilis Background

Missouri's public health goal is to have zero congenital syphilis cases. Unfortunately, similar to the national trend, Missouri's congenital syphilis cases have been increasing from ten (10) in 2016 to eighty-one (81) in 2022 (See Figure 1.), with a sharp increase in cases since 2019. This is an eight-fold increase in a preventable disease.

Figure 1. Congenital syphilis cases by year, Missouri, 2016-2022

Source: Missouri Department of Health and Senior Services, Office of Epidemiology, Missouri Health Surveillance Information System (WebSurv). Based on data as of September 13, 2023.

Symptoms of Syphilis

Treponema pallidum causes syphilis and can present in several stages. The chancre or ulcer of primary syphilis is commonly painless and may not be noted by infected persons as it resolves even without treatment. Most patients who seek care do so with secondary syphilis, whose symptoms include a rash that may involve the palms and soles, patchy hair loss, wart-like lesions (condyloma lata), and swelling of the lymph nodes (lymphadenopathy). Left untreated, syphilis can cause cardiac system abnormalities and neurological symptoms in later stages.

A pregnant woman can transmit syphilis to her child during any stage of syphilis and any trimester of pregnancy. However, the risk of transmission is highest if the mother has been infected recently. Syphilis infection during pregnancy increases adverse pregnancy outcomes, including preterm birth and stillbirth. Up to 40% of babies born to mothers with untreated syphilis (if infected within four years prior to delivery) will be stillborn or die in infancy. Congenital syphilis can lead to newborn and childhood illnesses, including hydrops fetalis, hepatosplenomegaly, rashes, fevers, failure to thrive, blindness, deafness, and deformity of the face, teeth, and bones.

Missouri DHSS Recommendations

Screening

- Providers should assess the sexual health of all patients and discuss STDs and HIV risks for the patient and partners of the patient.
- Providers should routinely test for syphilis in individuals who have signs or symptoms suggestive of infection. Individuals exposed to syphilis within the past 90 days should receive testing and presumptive treatment.
- All pregnant women in Missouri should be screened for syphilis three times regardless of perceived risk at the first prenatal visit.
- Women with risk for syphilis acquisition during pregnancy should also be tested in the third trimester (28 weeks), and at delivery (<https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm>).

- Women who experience a stillbirth after 20 weeks of pregnancy should be tested for syphilis.
- Infants should not be discharged from the hospital unless the mother has been tested for syphilis during pregnancy, preferably including the test during the delivery hospitalization.

Diagnosis and Treatment

Syphilis during pregnancy

- Two tests are required to diagnose syphilis, a non-treponemal test (NTT) assay (i.e., Venereal Disease Research Laboratory [VDRL] or Rapid Plasma Reagin [RPR]) and a confirmatory treponemal test (i.e., fluorescent treponemal antibody absorbed [FTA-ABS] tests, the *pallidum* passive particle agglutination [TP-PA] assay, etc.). Since false positive NTT tests are seen in pregnancy, confirmatory testing with a treponemal test is necessary to diagnose syphilis.
- Adequate treatment of syphilis in pregnant women as soon as possible during pregnancy dramatically decreases the rate of congenital syphilis.
- Only Benzathine penicillin G should be used in pregnant women.
- Patients with penicillin allergies should be desensitized by an allergist and treated with penicillin, as it is the only known effective antimicrobial for preventing maternal transmission to the fetus and treating fetal infection.
- Partners should (at a minimum) be presumptively treated (**2.4 million units of IM Benzathine penicillin G**) to prevent reinfection during pregnancy no matter their test results. Ideally, they should be evaluated for syphilis by a provider and staged and treated appropriately.
- Please refer to the full CDC STI Treatment Guidelines (<https://www.cdc.gov/std/treatment-guidelines/syphilis-pregnancy.htm>) for additional treatment information.

Congenital Syphilis in the infant

- Infected infants may be asymptomatic.
- Infants born to untreated mothers or mothers with inadequate treatment (including those treated <30 days prior to delivery) should be evaluated and treated for congenital syphilis per CDC guidelines (<https://www.cdc.gov/std/treatment-guidelines/congenital-syphilis.htm>).
- All neonates born to women who have reactive NTT and treponemal tests should be evaluated with a quantitative NTT serologic test (RPR or VDRL) and be examined thoroughly for evidence of congenital syphilis (see details in CDC treatment guidelines at <https://www.cdc.gov/std/treatment-guidelines/congenital-syphilis.htm>).

Questions should be directed to the Missouri Department of Health and Senior Services, Bureau of HIV, STD, and Hepatitis at 573-751-6439, or via email at STD@health.mo.gov.

Resources

1. 2021 CDC STI treatment guidelines <https://www.cdc.gov/std/treatment-guidelines/toc.htm>
2. National STD Curriculum <https://www.std.uw.edu/>
3. CDC Syphilis Provider Pocket Guide: <https://www.cdc.gov/std/syphilis/Syphilis-Pocket-Guide-FINAL-508.pdf>
4. National Network of STD Clinical Prevention Training Centers Clinical Consult Network: www.stdccn.org
5. [Rac M, Revell P, Eppes C. Syphilis during pregnancy: a preventable threat to maternal-fetal health. AJOG Dec 2016;1-12.](#)
6. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 7th ed. Elk Grove Village (IL): AAP; Washington, DC: American College of Obstetricians and Gynecologists; 2012. p. 426-432. <http://ebooks.aappublications.org/content/guidelines-for-perinatal-care-7th-edition>)

Target Audience

Local Health Departments, Infectious Disease Physicians, Hospital Emergency Departments, Infection Control Preventionists, Health Care Providers, Long Term Care Facilities, and Laboratories

Author

DHSS Bureau of HIV, STD, and Hepatitis, the State Chief Medical Officer, the State Chief Epidemiologist, and Division of Community and Public Health.

This information is current as of February 7, 2024 but may be modified in the future. We may continue to post updated information regarding the most common questions about this subject.



HEALTH UPDATE

Missouri Department of Health and Senior Services

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February 27, 2024

Update on Syphilis in Missouri

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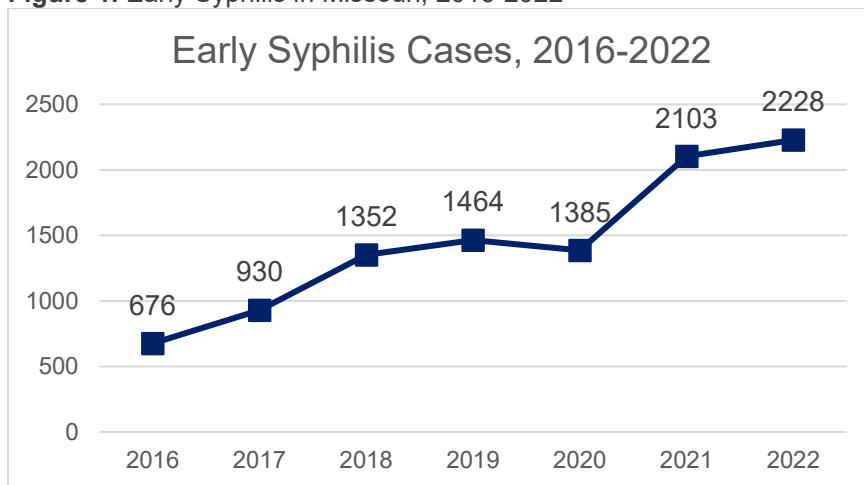
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Summary

The Missouri Department of Health and Senior Services (DHSS) continues to observe a sustained increase in the number of syphilis cases reported in the state. The number of early syphilis cases reported in Missouri increased by 230% from 2016 to 2022 (Figure 1.) (Reported case numbers in 2020 were likely an underestimation of the disease burden due to decreased testing that occurred during the COVID-19 pandemic.) The purpose of this DHSS Health Update is to alert health care providers of the significant continued increase in rates of syphilis among multiple populations including heterosexual men and women; gay, bisexual, and other men who have sex with men; and people who use drugs. A significant increase has also been observed in the number of reported congenital syphilis cases.

Figure 1. Early Syphilis in Missouri, 2016-2022



Source: Missouri Department of Health and Senior Services, Office of Epidemiology, Missouri Health Surveillance Information System (WebSurv). Based on data as of September 13, 2023.

Syphilis Background

Syphilis is a sexually transmitted disease (STD) that can have very serious complications for adults and newborns if left untreated. Initial symptoms of syphilis include a sore and/or rash that goes away after a few weeks without treatment, though serious health issues may emerge later without appropriate treatment. Syphilis can be treated and cured with antibiotics, yet many cases go undiagnosed and untreated, leading to increased transmission and future negative health consequences. Congenital syphilis occurs when a mother with untreated syphilis passes the infection on to her baby during pregnancy – causing miscarriages, premature births, stillbirths, or death of newborn babies. Infants with congenital syphilis can experience multiorgan system damage that may present at delivery or later in life.

Missouri's increase in syphilis cases was initially observed among gay, bisexual, and other men who have sex with men. However, other groups, including heterosexual men and women, have also experienced an increase in cases in recent years. Smaller metropolitan areas and rural counties throughout Missouri are experiencing a similar increase in cases, particularly among people who use drugs and their partners.

The continued high rates of STDs in Missouri, including syphilis and congenital syphilis, mirror nationwide trends seen in recent years. Ongoing public health efforts to reverse current trends will require a renewed commitment from, and continued partnership with healthcare providers.

Missouri DHSS Recommendations

- Providers should assess the sexual health of patients and discuss STD risks for the patient and partners of the patient.
- Providers should routinely test for syphilis in individuals who have signs or symptoms suggestive of infection. Individuals exposed to syphilis within the past 90 days should receive testing and preventive treatment.
- Sexually active gay, bisexual, and other men who have sex with men should be tested for syphilis annually or more frequently depending on risk.
- Pregnant women should be tested three times regardless of perceived risk: (1) at the first prenatal visit, (2) in the third trimester (28-32 weeks), and (3) at delivery. Bicillin LA is the only CDC-recommended treatment for pregnant women, including those who are allergic to penicillin. Pregnant women who are allergic to penicillin should be desensitized via consultation with an allergist and treated with Bicillin LA.
- Any woman who has a fetal death after 20 weeks gestation should be tested for syphilis.
- Individuals who are living with HIV who are sexually active should be tested for syphilis annually.
- Patients with diminished visual acuity, blindness, uveitis, panuveitis, optic neuropathy, interstitial keratitis, anterior uveitis, and retinal vasculitis should be tested for syphilis and referred to an ophthalmology specialist. If ocular syphilis is suspected, the patient should be treated according to the Centers for Disease Control and Prevention's (CDC's) 2021 treatment recommendations (see below under Additional Resources) for neurosyphilis and undergo a lumbar puncture with cerebrospinal fluid (CSF) examination.

Questions should be directed to the DHSS Bureau of HIV, STD, and Hepatitis at 573-751-6439 or via email at STD@health.mo.gov.

Resources

- Complete CDC testing and treatment recommendations: <https://www.cdc.gov/std/treatment-guidelines/default.htm>
- CDC Syphilis Pocket Guide: <https://www.cdc.gov/std/syphilis/Syphilis-Pocket-Guide-FINAL-508.pdf>
- DHSS Syphilis Overview: <https://health.mo.gov/living/healthcondiseases/communicable/stds/syphilis.php>

Target Audience

Local Health Departments, Infectious Disease Physicians, Hospital Emergency Departments, Infection Control Preventionists, Health Care Providers, Long Term Care Facilities, and Laboratories

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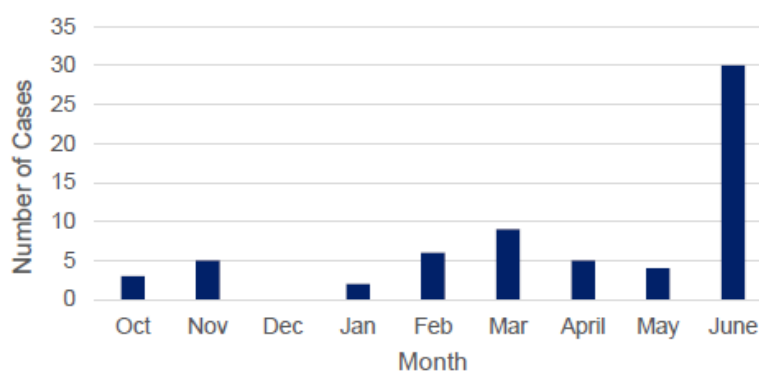
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Update on Emerging *Candida auris* Infection Cases in Missouri Health Care Facilities

Summary

The Missouri Department of Health and Senior Services (DHSS) continues detecting cases of *Candida auris* (*C. auris*) within health care facilities in the Saint Louis Metro area. The DHSS first identified locally acquired *C. auris* infection in October of 2023.

Figure 1. *C. auris* Cases Detected in Missouri by Month, October 2023-June 2024



While patients have been identified in health care facilities in the Saint Louis Metro area, patients may receive further care in other regions of the state. The DHSS HAI/AR program promotes interfacility communication of patient's *C. auris* status on transfer between healthcare facilities through use of an Interfacility Transfer Form, such as CDC's found [here](#). Additionally, upon admission health care personnel should assess patients' *C. auris* and other MDRO status by reviewing medical records and utilizing EHR or HL7, especially for patients admitted from long term acute care hospitals or ventilator units.

C. auris Background

C. auris is an emerging yeast that, due to resistance to many antifungal drugs, is considered an urgent antimicrobial resistance threat by the Centers for Disease Control and Prevention (CDC). *C. auris* spreads easily in health care settings and is difficult to treat due to drug-resistance. Invasive infections with *C. auris* are particularly concerning and have caused death in about one in three persons who developed severe disease due to this infection. According to the CDC's *C. auris* tracking tool, there were 2,377 clinical cases and 5,754 colonization/screening cases identified from January 2022 – December 2022 across 29 states.



C. auris mostly affects individuals with severe underlying conditions, those requiring complex medical care, as well as those with indwelling devices. Patients with invasive medical devices like breathing tubes, feeding tubes, catheters in a vein, or urinary catheters tend to be at increased risk for acquiring *C. auris* infection. Healthy people without these risk factors, including health care workers and family members, have a low risk for becoming infected with *C. auris*.

Transmission

C. auris can spread from one patient to another in health care settings. It can spread through close contact with infected or colonized patients and contaminated surfaces or equipment. *C. auris* can live on surfaces for several weeks. Contact with these surfaces allows the fungus to spread to other people. Once a patient has tested positive for *C. auris* infection or colonization, they are considered colonized for life and infection control measures should be utilized indefinitely.

Symptoms and Colonization

C. auris can cause infections in different parts of the body such as in the bloodstream, open wounds, and ears. The symptoms depend on the location and severity of *C. auris* infection. Symptoms may be similar to an infection caused by bacteria. There is not a common set of symptoms specific for *C. auris* infections. People can get *C. auris* on their skin and other body sites without getting sick or having an active infection with symptoms. Health care providers may refer to this as 'colonization.' Someone who is colonized can still contaminate surfaces or objects they contact with *C. auris*, which can then spread it to other patients.

Diagnosis

Health care providers can diagnose a patient as actively infected or colonized with *C. auris* in two ways:

- **Colonization screening**— a health care provider swabs the patient's skin by rubbing a swab near the armpits and groin and sends the swab to a laboratory for testing.
- **Clinical specimen testing**— If a patient is showing symptoms of an infection of an unknown cause, a health care provider may collect a clinical sample, like blood or urine. They usually test for many types of infections, including those caused by bacteria, and the results may show that the patient has *C. auris*.

Retesting patients infected or colonized with C. auris is not recommended and should not be used to change infection control measures. A negative test after a previous positive does not ensure that the patient no longer has C. auris on their skin or other body sites and will not spread it to others.

Treatment

Some *C. auris* strains have been resistant to all three main classes of antifungal medicines, meaning none are able to treat the infection. In this situation, multiple antifungal medicines or newer antifungals may be used to treat the infection. Most strains of *C. auris* found in the United States have been susceptible to echinocandins, although reports of echinocandin-resistant (or pan-resistant) cases are increasing. Patients who are colonized (have *C. auris* detected on their body but do not have symptoms of infection) should not be treated with antifungals for *C. auris*. There is no evidence this prevents future illness.

Epidemiology of *C. auris* in Missouri

C. auris was first detected in Missouri in late 2020. Between January 1, 2024 and June 30, 2024, DHSS has detected 56 additional cases with the majority in the St. Louis Metro area. At least one *C. auris* case has been detected in a variety of health care facilities including: Acute Care Hospitals, Long Term Acute Care Hospitals, Skilled Nursing Facilities, and Rehabilitation Hospitals. Additionally, some *C. auris* positive patients have also been receiving healthcare through hemodialysis and home health services.

Cases have continued to be largely identified through point prevalence surveys (PPS) conducted by health care facilities as part of epidemiologic investigation and public health surveillance. Colonized individuals have been detected via axilla/groin and rectal swabs, and clinical cases have been identified

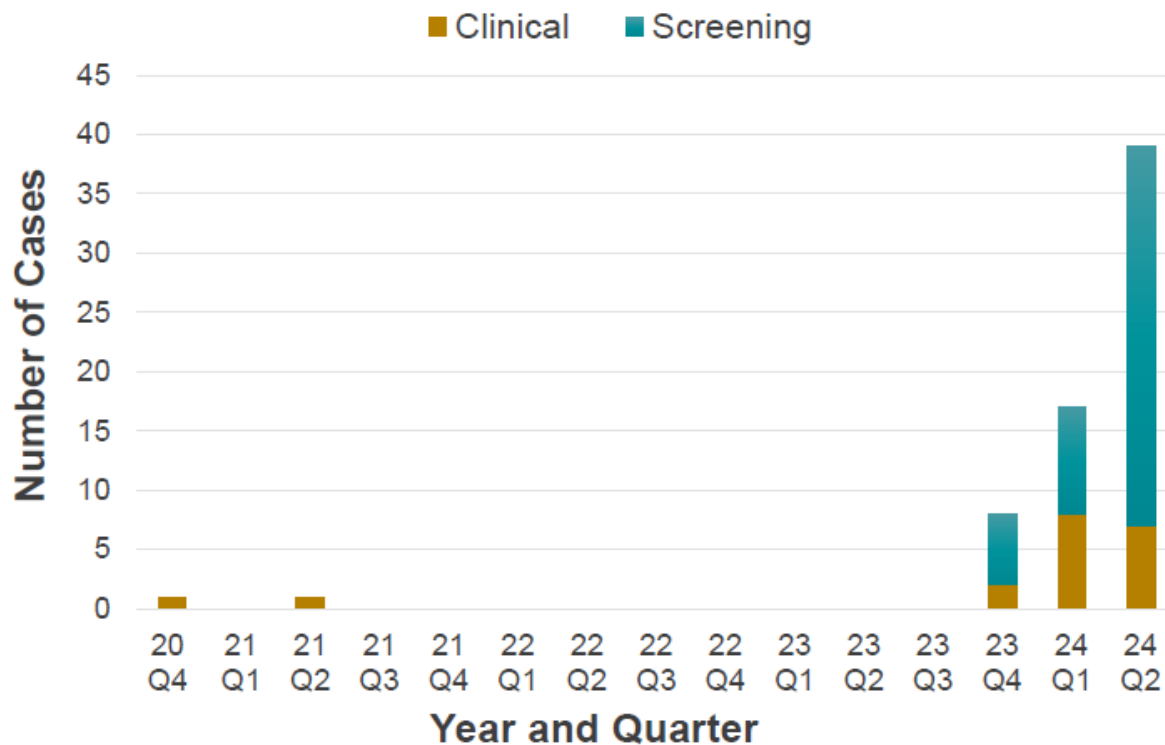


from positive tests of abdominal aspirate, blood, bile, bronchial wash, peritoneal dialysis fluid, sputum, tissue, urine and wounds.

From the 65 cases reported in Missouri since 2020:

- Patient age ranges from 26 to 93 years old with a median age of 63 years.
- Eighteen patients reported receiving health care in geographic areas outside of Missouri with a high *C. auris* incidence.

Figure 2. Number of *C. auris* cases detected in Missouri by Quarter, Q4 2020- Q2 2024



Missouri DHSS Recommendations

Infection Prevention and Control

The CDC and the Missouri DHSS recommends health care facilities take the following actions to identify and control further spread:

- Immediately initiate and regularly reinforce appropriate use of transmission-based precautions based on the setting (described below).
- Inform and educate appropriate personnel about the presence of a patient with *C. auris* and the need for rigorous adherence to infection control practices.
- Ensure strict adherence to hand hygiene and appropriate personal protective equipment (PPE) use. Alcohol-based hand sanitizer is effective against *C. auris* and is the preferred method for cleaning hands when they are not visibly soiled. Wearing gloves is not a substitute for hand hygiene.
- Perform thorough cleaning and disinfection of the patient care environment and any shared equipment (daily and terminal cleaning) used by patients with confirmed or suspected *C. auris*. Use a disinfectant active against *C. auris* identified by the Environmental Protection Agency (EPA) from [EPA List P](#).
- If possible, use dedicated medical equipment for patients with confirmed or suspected *C. auris*.
- Promote antimicrobial stewardship to limit the emergence of *C. auris* and other multi-drug resistant organisms (MDROs).

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Transmission-Based Precautions

Health care facilities should not decline admission based on colonization or presence of MDRO infection including *C. auris*. All patients with *C. auris* infection or colonization should be placed on the appropriate transmission based precautions based on the setting:

- **Acute care hospitals, post-acute care facilities (including long-term acute care hospitals)** should place patients with *C. auris* on contact precautions.
- **Skilled Nursing Facilities** should place patients on Enhanced Barrier Precautions (when contact precautions do not otherwise apply). More information on enhanced barrier precautions can be found here: <https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html>
 - **Skilled nursing facilities with ventilator units**, should initially place patients on contact precautions. Patients may be able to be moved to Enhanced Barrier Precautions.
- **Dialysis clinics and providers** should care for patients with *C. auris* by having health care personnel wear disposable gowns and gloves during patient care or when touching items at the dialysis station. Gowns and gloves should be removed and disposed of carefully, and hand hygiene should be performed when leaving the patient's station. Minimize exposure to other patients by placing the patient away from others or seeing the patient at the end of day.
- **Outpatient Settings** should care for patients with *C. auris* by having health care personnel wear disposable gown and gloves if extensive patient contact is anticipated or contact with infected areas is planned (e.g., debridement or dressing of colonized or infected wound). Gowns and gloves should be removed and disposed of appropriately, and hand hygiene should be performed when leaving the patient's room.
- **Home Health care settings** should care for patients with *C. auris* by having health care personnel wear disposable gown and gloves when entering the area of the home where providing patient care. Gowns and gloves should be removed and disposed of appropriately. Hand hygiene should be performed when leaving the patient care area. Minimize exposure to other patients by seeing the patient at the end of day.

Place all patients with confirmed or suspected *C. auris* infection or colonization in a private room. If a private room is not available:

- Patients infected or colonized with *C. auris* and/or other MDROs should be placed in rooms with patients colonized with the same organism(s). CDC does not recommend placing patients with *C. auris* in rooms with patients who have other types of MDROs.
- Avoid placing *C. auris* patients with patients who have indwelling devices (e.g., central venous catheter, tracheostomy tubes and mechanical ventilators), serious underlying medical conditions, or are otherwise immunocompromised.

Missouri DHSS does not currently recommend the discontinuation of precautions for a patient or resident with a current or history of *C. auris* colonization or infection.

Interfacility Communication

Robust communication at the time of transfer ensures the continuation of infection prevention and control measures during transitions of care. This can be accomplished via verbal report at the time of transfer, in the discharge summary, or through the use of an interfacility transfer tool.

- Upon admission, ask about a patient's *C. auris* and other MDRO status, if not included in the accompanying medical records.
- Upon admission, assess *C. auris* and other MDRO status for all patients by reviewing medical records and utilizing EHR or HL7, especially for patients being admitted from long term acute care hospitals or from ventilator units.
- Upon discharge, communicate a patient's *C. auris* and other MDRO status, including patients screened for an MDRO, but for whom laboratory results are not available at the time of transfer, to any receiving health care facility prior to transfer.
 - This should be done by including a written notification of the infection or colonization to the receiving facility in transfer documents. The referring facility should ensure that the

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documentation is readily accessible to all parties involved in patient transfer (for example, referring facility, medical transport, emergency department, receiving facility). CDC has a sample [Interfacility Transfer Form](#) that facilities can use.

Containment Response

A single case of *C. auris* (active infection or colonization) requires a robust containment response. The DHSS Healthcare Associated Infections/Antimicrobial Resistance (HAI/AR) Program may be conducting outreach to health care facilities and clinical laboratories with epidemiologic links to case patients or health care facilities with cases of *C. auris* infection. [Infection Control Guidance from CDC including environmental disinfection](#).

Colonization Screening

Missouri DHSS recommends screening patients for *C. auris* who meet any of the following criteria:

- Patients newly colonized or infected with *C. auris* (immediately notifiable)
- Guidance on *C. auris* screening of roommates or other close contacts
- Guidance on patient cohorting (i.e., grouping patients infected with the same infectious agents together to confine their care to one area and prevent contact with susceptible patients)
- Guidance of infection control interventions
- HAI Surveillance including reporting, specimen collection, and specimen submission to the Missouri State Public Health Laboratory (MSPHL).

Testing of the environment or equipment for *C. auris* is not routinely recommended. Likewise, testing of health care workers or family members who care for patients with *C. auris* (or an exposure to *C. auris*) is not routinely recommended.

Clinical Laboratories

Clinical laboratories processing specimens from residents receiving health care in Missouri should implement methods to detect *C. auris* as outlined below:

- Use the [CDC Candida auris laboratory resource](#) and algorithm to identify *C. auris* based on the available phenotypic laboratory method and initial species identification.
- If your laboratory does not have methodologies required to speciate *C. auris*, talk with the HAI/AR Program to evaluate the utility of forwarding isolates suspicious for *C. auris* for further testing at commercial or public health laboratories that can perform *C. auris* identification. Please forward any positive *C. auris* isolates to the Missouri State Public Health Laboratory (MSPHL).
- If possible, perform speciation for all yeast isolates from an inpatient in a health care facility (acute care hospital, LTACH, or SNF), including from both normally sterile and nonsterile body sites. This activity may be particularly useful in the three months following the release of this alert, as we seek to understand the local epidemiology of *C. auris* in Missouri.
- CDC recommends that all yeast isolates obtained from a normally sterile site be identified to the species level so appropriate initial treatment can be administered based on the typical, species-specific susceptibility patterns.
- Species-level identification of *Candida* isolates from non-sterile sites should be conducted in the following circumstances:
 - If clinically indicated in the care of the patient.
 - To detect additional colonized patients when a case of *C. auris* infection or colonization has been detected in a facility or unit.
 - If the patient has had an overnight stay in a health care facility within an identified domestic hotspot, or outside the U.S. in the previous year, especially in a country or region with documented *C. auris* transmission.
 - If the patient currently or previously resided in skilled nursing facilities with ventilated patients or in long term acute care hospitals.



Reporting

Health care facilities, providers and laboratories with suspected or confirmed cases of *C. auris* (active infection or colonization), should report them to the DHSS HAI/AR Program at 573-751-6113 or the DHSS Emergency Response Center (ERC) at 800-392-0272. *C. auris* is implicitly reportable in Missouri as an emerging or unusual disease per the Regulatory Documentations of Reportable Diseases and Conditions in Missouri ([19 CSR 20-20.020](#)). *C. auris* became nationally notifiable in 2018.

Please contact the Missouri DHSS HAI/AR Program for:

- Patients newly colonized or infected with *C. auris* (immediately notifiable)
- Guidance on *C. auris* screening of roommates or other close contacts
- Guidance on patient cohorting (i.e., grouping patients infected with the same infectious agents together to confine their care to one area and prevent contact with susceptible patients)
- Guidance of infection control interventions
- HAI Surveillance including reporting, specimen collection, and specimen submission to the Missouri State Public Health Laboratory (MSPHL).

Full Background information on *C. auris* can be found in the original Emerging *Candida auris* Infection Cases in Missouri Health Care Facilities Health Alert from December 6, 2023 found at <https://health.mo.gov/emergencies/ert/alertsadvories/pdf/alert120623.pdf>

The Missouri DHSS HAI/AR Program can be contacted at the following email address: info@health.mo.gov

References

[Worsening Spread of Candida auris in the United States, 2019 to 2021 | Annals of Internal Medicine \(acpjournals.org\)](#)

[CDC C. auris Homepage](#)

Infection Control Guidance: *Candida auris*

[EPA List P](#)

[Implementation of Personal Protective Equipment \(PPE\) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms \(MDROs\) | HAI | CDC](#)

[Identification of Candida auris | Candida auris | Fungal Diseases | CDC](#)

Target Audience

Local Health Departments, Infectious Disease Physicians, Hospital Emergency Departments, Infection Control Preventionists, Health Care Providers, Long Term Care Facilities, Dialysis Clinics, and Laboratories

Author

MDHSS Healthcare Associated Infections/Antimicrobial Resistance Program, the State Epidemiologist, and Division of Community and Public Health.

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